MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01603

CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Cecil

City or town Rowlandsville R.F.D. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 yrs

Hospital, institution, or street address where death occurred: near Appleton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Cecil

City or town Rowlandsville R.F.D. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bertha Biddle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24 - 1872

8. AGE: Years 72 | Months 5 | Days 19 | If less than one day hrs. min.

9. Birthplace Cecil Co Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name George Biddle

13. Birthplace Cecil Co Md

MOTHER 14. Maiden name Emma Jane Walker

15. Birthplace Cecil Co Maryland

16. Informant Mrs Edward A. Herbert

Address 2606 Monroe Ave Wilmington Del

17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb 15 - 45 (month) (day) (year)

Cemetery or crematory Head of Christiana Del

Location Newark Del R.D.

18. Funeral director R. V. Jones

Address Newark Del

19. Feb 14 1945 F R Teague

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1945; at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 1945 to Feb 12 1945

and that I last saw h alive on Feb 12 1945

	DURATION
Immediate cause of death Uremia & Bronchopneumonia	Feb 10 & 12
Due to Pneumonia Influenzal (Bilateral)	Jan 1939
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur L. Mercer M.D. M. D. or other

Address 136 W. Main Newark Date signed 2/13/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

01604

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs. 8 mo. 8 da.
Hospital, institution, or street address where death occurred:
Veterans Administration Facility, Perry Point
How long in hospital or institution? Same as above Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. -
(If rural, give LOCATION)
2.(a) If veteran, name war: W.W. I

3.(a) FULL NAME: BRYAN, Orlando

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ///// Mary Bryan (Maiden name unknown)
6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): May 30, 1886

8. AGE: Years	Months	Days	If less than one day
58	8	12	- hrs. - min.

9. Birthplace: Trenton, N.C. (Town, county, and state)
10. Usual occupation: Farm helper
11. Industry or business:
FATHER 12. Name: John W. Bryan
13. Birthplace: Jones County, N.C.
MOTHER 14. Maiden name: Nancy Koonce
15. Birthplace: Jones County, N.C.
16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof 2-13-1945 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.
18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.
19. Feb. 13 19 45 (Date rec'd by registrar) Irma E. Dunphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 11 19 45 at 10:25P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3 19 34 to Feb. 11 19 45 and that I last saw him alive on February 11 19 45

Immediate cause of death	DURATION
Epilepsy	30 years
Due to	
Due to	
Other conditions: Psychosis with epileptic deterioration	11 yrs
Arteriosclerosis, general and Cerebral (Include pregnancy within 3 months of death)	11 yrs.

Major findings of operations: -
Date of op. -
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of -
Where did injury occur? - (City or town) - (County) - (State)
Injured at home, farm, industry, public place (where?): -
Means of injury: - Injured at work? -

23. SIGNATURE: E. E. Trollinger
E. TROLLINGER, Lt. Col., M.C., Clinical Director or other
Address: Veterans Administration, Perry Point, Md.
Date signed: 2-13-45

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Dr Balto. 01605

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Mo.

Hospital, institution, or street address where death occurred: #50 Hollingsworth Manor.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. #50 Hollingsworth Manor

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Harry Elwood Burkins

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1944

8. AGE: Years	Months	Days	If less than one day
	1	28	..... hrs. ..... min.

9. Birthplace: Elkton, Md. (Town, county, and state)

10. Usual occupation: None.

11. Industry or business

FATHER — 12. Name: Charles Burkins

13. Birthplace: Rising Sun, Md.

MOTHER — 14. Maiden name: Catherine Gaeppert.

15. Birthplace: Gilbertsville, Pa.

16. Informant: Charles Burkins

Address: Elkton Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Feb 19/45 (month) (day) (year)

Cemetery or crematory: Rising Sun

Location: Rising Sun Md.

18. Funeral director: H. W. Rippin

Address: Elkton, Md.

19. Feb 19 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 16 1945, at 8 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 14 1945, to Feb 16 1945 and that I last saw him alive on Feb 16 1945

Immediate cause of death	DURATION
Bronchopneumonia	
Due to: Bronchitis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Herbert Kelly M.D. M. D. or other

Address: Elkton Md Date signed Feb 16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01606

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Bainbridge, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 days

Hospital, institution, or street address where death occurred: US Naval Hospital, NavTraCen Bainbridge, Maryland.

How long in hospital or institution? 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Georgia County: Troup

City or town: LaGrange.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 200 Addie Street.
(If rural, give LOCATION)

2.(a) If veteran, name war: WORLD WAR II

3. (a) FULL NAME: Handley Clennis B U R S O N

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	SINGLE

6.(b) Name of husband or wife: not married

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 9/27/26

8. AGE: Years	Months	Days	If less than one day
18	4	25	____ hrs. ____ min.

9. Birthplace: Rock Mills, Alabama
(Town, county, and state)

10. Usual occupation: US Navy

11. Industry or business:

FATHER
12. Name: William Jewell BURSON
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: US Naval Hospital, NavTraCen
Address: Bainbridge, Maryland.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb. 24 1945 (month) (day) (year)
Cemetery or crematory: To Hammett & Grover Funeral Home
Location: LaGrange, Georgia

18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.

19. Feb. 24 1945 Irma E. Doughty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 February, 1945 19__ at 11:55PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 20 February, 1945 19__ to 22February 19 45 and that I last saw him alive on 22 February, 1945 19__

Immediate cause of death	DURATION
POISONING, THERAPEUTIC, ACUTE (Sulfadiazine) prophylactic)	5 days
Due to	
Due to	
Other conditions: Pneumonia, lobar	3 days

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: Exfoliative dermatitis, bronchitis and oesophagitis, lobar pneumonia.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: H.B. Black
H.B. BLACK, Lieut. (MC) USN
M. D. or other

Address: US Naval Hospital, NavTraCenter
Bainbridge, Md. Date signed: 2/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

01607

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Minutes

Hospital, institution, or street address where death occurred: Union Hospital.

How long in hospital or institution? 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Del. County: New Castle

City or town: Rural Near Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. 2

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Ruth Ann Case

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 17, 1943

8. AGE: Years: | Months: 1 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Elkton, Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: James K. Case

13. Birthplace: Felton, Del.

MOTHER — 14. Maiden name: Elizabeth Scott.

15. Birthplace: Chester, Pa.

16. Informant: Elizabeth Case

Address: Elkton R.D. 2 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 15, 1945 (month) (day) (year)

Cemetery or crematory: Barrette Chapel

Location: Kent Co. Md. Del.

18. Funeral director: H W Pilchard

Address: Elkton, Md.

19. Feb 15 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 13 19 45, at 850 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 19 45, to Feb 13 19 45

and that I last saw h[illegible] alive on Feb 13 19 45

Immediate cause of death	DURATION
Bronchopneumonia	
Due to: Bronchitis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J Herbert Bell M.D. (M. D. or other)

Address: Elkton Md Date signed: 2/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

01608

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Veterans Administration (CECIL) (COUNTY)
City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W. Va. County: Tucker County
City or town: Davis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: None
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: CHRYSTAL, Edward T.

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: -
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): Oct. 14, 1887

8. AGE:	Years	Months	Days	If less than one day
	57	3	19	- hrs. - min.

9. Birthplace: Hutton, W.Va. (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: -

FATHER
12. Name: Michael J. Chrystal
13. Birthplace: Oakland, Md.

MOTHER
14. Maiden name: Margaret Joyce
15. Birthplace: Terra Alta, W. Va.

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point,

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2-3-1945 Md. (month) (day) (year)
Cemetery or crematory: Catholic Cemetery
Location: Terra Alta, W. Va.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Feb. 3 19 45 (Date rec'd by registrar) Irene E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2 1945 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31 1945, to February 2 1945 and that I last saw him alive on February 2 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage, with Hemiplegia right	9 hrs.
Due to:	
Due to:	
Other conditions: Psychosis due to alcoholism, acute	3 weeks

(Include pregnancy within 3 months of death)

Major findings of operation: -
Date of op.: -
Autopsy results: Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of: -
Where did injury occur? - (City or town) - (County) - (State)
Injured at home, farm, industry, public place (where?): -
Means of injury: - Injured at work? -

23. SIGNATURE: O. E. Trollinger
O. E. TROLLINGER, Lt.Col., M.C., U.S.A. or other M.C.
Clinical Director, Veterans Administration, Perry Point, Md.
Date signed 2-3-45

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

01609

Reg. Diat. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton RD 1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, Institution, or street address where death occurred:
Union Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton rd RD 1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rose Cross

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Orlando G Cross
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 2 1871

8. AGE:

Years	Months	Days	If less than one day
73	2	7	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business: —

FATHER
12. Name: no information
13. Birthplace: Germany

MOTHER
14. Maiden name: no information
15. Birthplace: Germany

16. Informant: Orlando G Cross
Address: Elkton rd RD 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 12 1945 (month) (day) (year)
Cemetery or crematory: Elkton cemetery
Location: Elkton Md
19. Funeral director: H W Pippin
Address: Elkton Md

19. Feb 12 1945 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9 19 45 at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 7 19 45, to Feb. 9 19 45
and that I last saw h... alive on Feb. 9 19 45

Immediate cause of death	DURATION
Concussion of Brain	
Due to: Fall (accidental)	
Due to:	
Other conditions: Fractured Left Humerus	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of Feb. 7
Where did injury occur? RD # 1 (City or town) Cecil (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Injured at work?

23. SIGNATURE: Jno J Cassaday M. D. or other
Address: Elkton Date signed FEB 12 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01619 45
Reg. Dist. No.

1. PLACE OF DEATH:
County Cecil
City or town Outside Rising Sun.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Cecil
City or town Outside Rising Sun.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Martha J. Davidson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife John Davidson
6.(c) If alive, give age 75 years
7. Birth date of deceased (mo., day, yr.) Feb. 3. 1868

8. AGE: Years	Months	Days	If less than one day
77		1	hrs. min.

9. Birthplace North East. Cecil Co. Md.
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name Thomas Astley
13. Birthplace Md.
MOTHER 14. Maiden name Annie Trimble
15. Birthplace Md.
16. Informant John Davidson
Address Rising Sun Md.
17. Buried Date thereof Feb 7 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Poplar Hill Cem
Location Calvert Md.
18. Funeral director J. E. Tyson
Address Rising Sun Md.
19. Feb 6 1945 E. M. Worthington
(Date rec'd by registrar) Registrar

Permit issued 2-6-45

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1945, at 1300 hr.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Coronary	
Due to Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE R. L. Dodson M.D. Medical Examiner for Cecil County
M. D. or other
Address Rising Sun Md. Date signed 2/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

01611

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (29)

CERTIFICATE OF DEATH

Reg. Dist. No. 96

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: CECIL
City or town: Bainbridge, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos., 9 days
Hospital, institution, or street address where death occurred: US Naval Hospital, NavTraCen, Bainbridge, Md.
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County:
City or town: Philadelphia
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2555 S. 61st., St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: WORLD WAR II ✓

3.(a) FULL NAME: DONNELLY, James Edward, Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Not married
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4/18/20

8. AGE: Years	Months	Days	If less than one day
24	9	16	hrs. min.

9. Birthplace: Philadelphia, Penna.,
(Town, county, and state)
10. Usual occupation: US NAVY
11. Industry or business:

FATHER
12. Name: James Edward Donnelly, Sr.,
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: US Naval Hospital NavTraCenter
Address: Bainbridge, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb 5 1945 (month) (day) (year)
Cemetery or crematory:
Location: to Philadelphia, Pa.
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.

19. Feb 5 1945 (Date rec'd by registrar) U.S. Irma E. Dempsey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 February 1945, at 10:50P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 January 1945 to 3 Feb. 1945 and that I last saw him alive on 3 February 1945

	DURATION
Immediate cause of death: Peritonitis	
General, primary, pneumococcal	5 days
Due to: Subsequent to catarrhal fever,	
acute.	14 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Peritonitis, general, primary
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harry C. Oard
M. D., or other
Address: U.S. Naval Hospital, Bainbridge, Md. Date signed: 4 Feb. 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01612

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: CECIL

City or town: VETERANS ADMINISTRATION, PERRY POINT, MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months, 9 days

Hospital, institution, or street address where death occurred:

VETERANS ADMINISTRATION? PERRY POINT, MD.

How long in hospital or institution? SAME AS ABOVE

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County: -

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 903 F Street, N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW I ✓

3.(a) FULL NAME: DORSEY, Roland C.

3.(b) Social Security Number: 0 -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife: Mrs. Isabel (Maiden name unknown)

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): November 16, 1896

8. AGE: Years	Months	Days	If less than one day
48	3	4	- hrs. - min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: -

FATHER — 12. Name: Edward F. Dorsey

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Gertrude Amanda

15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 2-22-45 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: Pennington & Son

Address: Pennington & Son, Havre de Grace, Maryland

19. Feb. 22 19 45 Irma E. Daugherty Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20 19 45 at 11:45P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 11 19 44 to Feb. 20 19 45

and that I last saw him alive on February 20 19 45

Immediate cause of death: Cerebral Hemorrhage — DURATION: 4 Da.

Due to: Cerebral Arteriosclerosis — DURATION: Over 1 yr.

Due to:

Other conditions: Psychosis with organic brain disease, cerebral thrombosis — DURATION: Over 1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.: -

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? - (City or town) - (County) (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: A. E. Hollinger

A. E. HOLLINGER, Lt. Col., M.C., Chief Surgeon and Director, Veterans Administration

Address: Perry Point, Md. Date signed: 2-21-45

01613

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: CECIL
City or town: BAINBRIDGE MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, Institution, or street address where death occurred: US Naval Hosp. Naval Training Center, Bainbridge, Md.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: PENNA County: HARRISBURG
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4601 DETTY STREET
(If r... WORLD WAR II
2.(a) If veteran, name war ✓

3.(a) FULL NAME: Ray Billett ESHENOUR

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: Betty Jane ESHENOUR
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 12 June, 1917

8. AGE: Years	Months	Days	If less than one day
27	8	0	...hrs. ...min.

9. Birthplace: HARRISBURG, PENNSYLVANIA
(Town, county, and state)

10. Usual occupation: US NAVY

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: US NAVAL HOSPITAL, NAV TRA CEN
Address: BAINBRIDGE, MARYLAND

17. Removal (Burial, cremation, or removal. Which?) Date thereof Feb. 14 1945 (month) (day) (year)
Cemetery or crematory: To S.S. Fackler Funeral Home 1312 Derry St.
Location: Harrisburg, Pa.

18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.

19. 2/14/45 Irene E. Daugherty
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 Febuary, 1945 at 7:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Feb. 1945 to 12 Feb. 1945 and that I last saw h... alive on 12 Feb. 1945

Immediate cause of death	DURATION
Lobar pneumonia	
Due to Streptococcus hemolyticus	4 days
Due to	
Other conditions Fibro-purulent pleurisy	4 days.
Pericarditis acute	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: PENNA Harry C. Oard M.D. M. D. or other
HARRISBURG
Address: B Naval Hosp. Bainbridge, Md. Date signed 13 Feb 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

01614

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil Co.
City or town: Rural Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Weeks
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Rural Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural Havre de Grace
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Elizabeth Taylor Hughes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Amos H. Hughes
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Sept. 6, 1864

8. AGE: Years	Months	Days	If less than one day
80	5	7	...hrs. ...min.

8. Birthplace: Harford Co. Md.
(Town, county, and state)
10. Usual occupation: Home Duties
11. Industry or business:
FATHER 12. Name: John M. Mackelvs
13. Birthplace: Del.
MOTHER 14. Maiden name: Elizabeth Davies
15. Birthplace: Wilmington, Del.
16. Informant: Mrs. Ethel M. Hopkins
Address: Havre de Grace, Md. R.D. #2
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 21 1945 (month) (day) (year)
Cemetery or crematory: Rock Run
Location: Harford Co. Md.
18. Funeral director: R. Madison Mitchell
Address: Havre de Grace, Md.
19. Feb 20 1945 (Date rec'd by registrar) Irene E. Dunlap (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 19 1945, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan - 15 1945, to Feb 15 1945, and that I last saw her alive on Feb 15 1945

Immediate cause of death	DURATION
Chronic Myocarditis	10 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: E. H. Benson M. D.
M. D. or other
Address: Port Deposit Md. Date signed: 2/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

01615

CERTIFICATE OF DEATH

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Principio Furnace, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:
Principio Furnace, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Havre De Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William Norris Jackson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ella Fisk Jackson

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): Jan. 13, 1888

8. AGE: Years	Months	Days	If less than one day
57	0	30	hrs. min.

9. Birthplace: Principio Furnace, Cecil, Md.
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Tourist Camp

FATHER
12. Name: Walter T. Jackson
13. Birthplace: Principio Furnace, Cecil Co, Md.

MOTHER
14. Maiden name: Nellie Moore
15. Birthplace: Harford Co., Md.

16. Informant: Debbie a Jackson
Address: Principio Furnace Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 15 1945 (month) (day) (year)

Cemetery or crematory: St. Marks

Location: Perryville, Md (Rural)

18. Funeral director: Lee Patterson & Son

Address: Perryville, Md.

19. Feb. 15 1945 (Date rec'd by registrar) Irene E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 12 1945, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 11 1945 to Feb 12 1945 and that I last saw him alive on Feb. 12 1945

Immediate cause of death	DURATION
Acute Dilatation of Heart	2 hr
Due to: Chronic Valvular Heart Disease	10 yr
Due to:	
Other conditions	

Md.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. F. Magraw M. D. or other

Address: Perryville Md Date signed 2/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01616

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs. 2 mo. 19 da.

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Unknown County: -

City or town: No permanent residence

(If outside city or town limits, write RURAL and give nearest town)

Street No.: -

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: THOMAS J. KENNEDY

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): January 8, 1892

8. AGE: Years	Months	Days	If less than one day
53	1	18	- hrs. - min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ?

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Veterans Administration Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 3-1-1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. March 1, 1945 (Date rec'd by registrar) Irene E. Douglas, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 26, 1945, at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 7, 1924, 19..., to Feb. 26, 1945, and that I last saw him alive on February 26, 1945.

Immediate cause of death	DURATION
Coronary Occlusion	3 da.
Due to: Coronary Arteriosclerosis Over 1 yr.	
Due to:	
Other conditions: Dementia Precox, Paranoid Over 20 yrs.	

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.: -

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: H. G. Pennington

H. G. PENNINGTON, Lt. Col., M.C., Clinical Director, Veterans Administration, Perry Point, Md. (M.D. or other)

Address: Perry Point, Md. Date signed: 2-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01617

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Caroline
City or town: Denton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Louis Josiah Knotts

3.(b) Social Security Number 215-03-0115

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Alicia Knotts
6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): June 17. 1900.

8. AGE: Years: 44 | Months: 7 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Ridgely Md.
(Town, county, and state)

10. Usual occupation: Foreman Warehouse

11. Industry or business: Trimpe Explosives

FATHER
12. Name: Louis L Knotts
13. Birthplace: Curtis Corner Md.

MOTHER
14. Maiden name: Agnes Lynch
15. Birthplace: Ridgely, Md.

16. Informant: Mrs Alicia Knotts
Address: Denton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 3 1945 (month) (day) (year)
Cemetery or crematory: Holy Cross
Location: Near Denton, Maryland

18. Funeral director: H. W. Tilghman
Address: Elkton, Md

19. Feb 7 1945 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 1 1945 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County
Address: Denton Md. Date signed: 2-1-45 M. D. or other

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01618

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 207 N. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Miss Edna Howard Lee

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 6 1883

8. AGE: Years	Months	Days	If less than one day
61	2	12	..... hrs. ..... min.

9. Birthplace: Elkton Md
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: John L Lee
13. Birthplace: Cecil Co Md

MOTHER
14. Maiden name: Laura Howard
15. Birthplace: Elkton Md

16. Informant: Mrs Helen Wells Wright
Address: Conowingo Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 21 1945 (month) (day) (year)
Cemetery or crematory: Presbyterian Elkton
Location: Elkton Md
18. Funeral director: P. T. Jones
Address: Newark Del

19. Feb 19 1945 (Date rec'd by registrar) H Brayer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 18 1945, at 9:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 16 1945, to Feb 18 1945
and that I last saw her alive on Feb 17 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A. T. Morrison, M.D.
M. D. or other
Address: Elkton, Md. Date signed 2-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

CERTIFICATE OF DEATH

01619

Reg. Dist. No. 93

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred: Union Hospital.
How long in hospital or institution? 3 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil.
City or town: Elkton, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: High St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: William Mahon

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Widowed

6.(b) Name of husband or wife: No Inf.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): No Inf. 1870

8. AGE: Years: 75 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Penna.
(Town, county, and state)

10. Usual occupation: at Home

11. Industry or business

FATHER
12. Name: No Inf.
13. Birthplace

MOTHER
14. Maiden name: No Inf.
15. Birthplace

16. Informant: Hospital Records
Address: Union Hosp. Elkton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 14/45 (month) (day) (year)
Cemetery or crematory: Elkton
Location: Elkton, Md

18. Funeral director: H. W. Pepper
Address: Elkton, Md.

19. Feb 14 1945 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 12, 1945, at 6 10 a. M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Feb. 11, 1945, to Feb. 12, 1945, and that I last saw h... alive on Feb 11, 1945.

Immediate cause of death	DURATION
Acute Heart Failure	
Due to: Chronic Myocarditis;	
Contributory duration: not stated.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Milford N. Sprecher M. D. or other
Address: Elkton, Md Date signed: Feb. 13

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01620

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Bainbridge, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Days.

Hospital, Institution, or street address where death occurred: US Naval Hospital, NavTraCenter, Bainbridge, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Alabama County:

City or town: Andalusia
(If outside city or town limits, write RURAL and give nearest town)

Street No. 200 Attic Street.
(If rural, give LOCATION)

2.(a) Ll veteran, name war: WORLD WAR II ✓

3. (a) FULL NAME: Edward (None) McGHEE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single.

6.(b) Name of husband or wife: not married

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4-23-26

8. AGE:	Years	Months	Days	If less than one day
	18	9	24	hrs. min.

9. Birthplace: Andalusia, Alabama
(Town, county, and state)

10. Usual occupation: US Navy

11. Industry or business:

FATHER
12. Name: Eddie McGHEE
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: US Naval Hospital, NavTraCenter
Address: Bainbridge, Maryland.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb. 19, 45 (month) (day) (year)

Cemetery or crematory:
Location: Andalusia, Alabama

18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.

19. Feb 19 19 45 (Data rec'd by registrar) James E. Dunglinson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 February, 1945 19 at 2:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17Feb1945 (2:45PM) 19 to 17Feb1945 (2:55PM)

and that I last saw him alive on 17 February, 1945. 19

Immediate cause of death	DURATION
CARCINOMA, STOMACH	Undet
Due to	
Due to	
Due to	
Other conditions: Hemorrhage, gastric	6 hours

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: Carcinoma of stomach, metastasis.

PHYSICIAN: Please underline the cause to which death should be charged statistically. hemorrhage.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Harry S. Levine M.D.
Harry S. Levine, M.D.
M. D. or other

Address: Naval Hospital, Bainbridge, Md. Date signed: 2/17/45

M

MARGIN RESERVED FOR BINDING

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

01621

Reg. Dist. No. 9-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Stubbs nursing home 3 months

Hospital, Institution, or street address where death occurred: Stubbs nursing home 3 months

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. R D 4

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah R Miller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 1 1857

8. AGE: Years: 84 | Months: 8 | Days: 3 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Union Cecil Co Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: William J. Miller

13. Birthplace: Md

MOTHER — 14. Maiden name: Jane McCullough

15. Birthplace: Md

16. Informant: Mrs R. C. Simpers

Address: north East Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 7 45 (month) (day) (year)

Cemetery or crematory: Union

Location: Elkton R. D 4

18. Funeral director: Joseph R Shaw

Address: north East Md

19. Feb 7 1945 Mrs Ralph A Hill Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 4 1945 at 8 40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 28 1944 to Feb. 4 1945 and that I last saw h... alive on Feb. 4 1945

Immediate cause of death	DURATION
Uremia	8 days
Due to: Cardio renal renal	Several
Due to: disease	years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Chesapeake City Md Date signed: Feb 7 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01622

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: E Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Russel Mullins

3.(b) Social Security Number: 229-12-6690

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Divorced.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 25, 1905

8. AGE: Years	Months	Days	If less than one day
39	11		hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Waiter
11. Industry or business
FATHER — 12. Name: J. M. Mullins
13. Birthplace: Clintwood, Va
MOTHER — 14. Maiden name: Mattie Rowe
15. Birthplace: Grundy, Va
16. Informant: J. R. Mullins
Address: Degger, W. Va
17. Burial & transporting (Burial, cremation, or removal. Which?) Date thereof: March 1/45 (month) (day) (year)
Cemetery or crematory: Mullens
Location: Corlew, W. Va
18. Funeral director: H. W. Tuppens
Address: Elkton, Md.
19. Feb 27 1945 H R Fraser
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 26 1945, at 2:30 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Febru 18 1945 to Feb. 26 1945, and that I last saw h... alive on Feb. 26 1945

	DURATION
Immediate cause of death: Heart-Failure	Feb. 1/4
Due to: Cardio-Renal Disease with	
Due to: hy. pertension and Bronchs-pneumonia.	Feb. 1/4
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Mc Ford W. Brecher, M.D. M. D. or other
Address: Elkton, Md. Date signed: Feb. 1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

01623

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Colora
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Colora
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Louise Hessey Murphy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife: Harry L. Murphy Sr.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 24, 1877

8. AGE: Years	Months	Days	If less than one day
67	10	25	hrs. min.

9. Birthplace: Cecil Co. Md.
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business
FATHER 12. Name: Henry H. Hessey
13. Birthplace: Cecil Co. Md
MOTHER 14. Maiden name: Sarah B. Lynch
15. Birthplace: Blackbird, Dela.
16. Informant: Harry L. Murphy Sr.
Address: Colora, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 21 1945 (month) (day) (year)
Cemetery or crematory: West Nottingham
Location: Colora, Md. Rural
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. Feb 21 1945 (Date rec'd by registrar) Irene E. Dougherty (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 18 1945, at 5.30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 9 1945 to Feb. 15 1945
and that I last saw h[er] alive on Feb. 15 1945

	DURATION
Immediate cause of death: Uremic Myocarditis	5 yrs
Due to: Uremic Arthritis.	5 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. J. Brown M.D. M. D. or other
Address: Port Deposit Date signed: 2/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01624

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs. 8 mo. 23 days.
Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: -
City or town: Baltimore,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 916 Hillman Street.
(If rural, give LOCATION)
2.(a) If veteran, name war: W. W. I

3.(a) FULL NAME: JOHN H. OAKLEY

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	(Widower)

6.(b) Name of husband or wife: -

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): 3-15-1893

8. AGE: Years	Months	Days	If less than one day
51	10	17	- hrs. - min.

9. Birthplace: Dunnsville, Va. (Town, county, and state)
10. Usual occupation: Cook
11. Industry or business: -

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: HOSPITAL RECORDS
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2-3-1945 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Md.

18. Funeral director: Mrs. Katie R. Williams for Ernest Smigold
Address: Miss Katie R. Williams, 322 N. Schroeder St., Baltimore, Md.

19. Feb. 3 19 45 Irma E. English - Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 1 19 45 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9, 19 38, to February 1 19 45 and that I last saw him alive on February 1 19 45

Immediate cause of death	DURATION
Syphilis of Central Nervous System	
Meningo-encephalitic Type	5 yrs. 10 mo
Due to: Myocarditis, chronic, cause undetermined	6 yrs.
Due to:	
Other conditions: Psychosis-~~of~~ with syphilis of central nervous system, Meningo-Encephalitic Type.	5 yr. 10 mo.

(Include pregnancy within 3 months of death)

Major findings of operations: - Date of op.: -

Autopsy results: -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of: -
Where did injury occur? - (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -
Means of injury: - Injured at work? -

23. SIGNATURE: A. E. Trollinger
A. E. TROLLINGER, Lt. Col., M.C. Clinical Director, Veterans Administration
Address: Date signed: 2-1-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
MAR 1 - 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

01625

Reg. Dist. No. 91

1. PLACE OF DEATH:
County: Cecil
City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Biddle St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Elsie O Pierce

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Henry L Pierce
6.(c) If alive, give age: 75 years
7. Birth date of deceased (mo., day, yr.): Aug 3 1872

8. AGE: Years	Months	Days	If less than one day
72	6	4	hrs. 0 min.

9. Birthplace: Chesapeake City Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Benjamin Davenport
FATHER 13. Birthplace: London England
MOTHER 14. Maiden name: Malala Stapples
MOTHER 15. Birthplace: Cecil Co Maryland
16. Informant: Vinton D Pierce
Address: Chesapeake City Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feby 10 1945 (month) (day) (year)
Cemetery or crematory: Bethel Cemetery
Location: Chesapeake City Md R D
18. Funeral director: H. W Pitcher
Address: Elkton Md
19. February 10 1945 (Date rec'd by registrar) Jessie Beckett H. Beck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Febry 8 1945, at 2 45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943 to Feb 8 1945
and that I last saw h[illegible] alive on Febry 7 1945

Immediate cause of death	DURATION
Concussion of Stomach	
Due to	
Due to	
Other conditions Carcinoma of Liver	

(Include pregnancy within 3 months of death)
Major findings of operation: Duodenal obstruction — gastroenterostomy done Date of op. 1943
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. P Davis M. D. or other
Address: Chesapeake City Md Date signed 2/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01626

Reg. Dist. No. 90

1. PLACE OF DEATH:
County Cecil
City or town Rural Earlville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs.
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)
State Maryland County Cecil
City or town Rural - Earlville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Evelyn Rhoades

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

8.(b) Name of husband or wife Geo. P. Rhoades
Feb 25 1863 8.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
82	0	0	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name James Spear
13. Birthplace Md.
MOTHER 14. Maiden name Sarah Ann Esmond
15. Birthplace Md.
16. Informant Louis Rhoades
Address Rural Earlville. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 28. 1945 (month) (day) (year)
Cemetery or crematory Bethel Cemetery
Location Bethel Md.
18. Funeral director Edward Williams
Address Millington. Md.
19. Feb 28 1945 (Date rec'd by registrar) Lemuel Benka Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1945 at 1 00 M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 1944 to Feb 25 1945
and that I last saw h alive on Feb 25 1945

Immediate cause of death	DURATION
Carcinoma of Stomach	Several Months
Due to	
Due to	
Other conditions Hemorrhoids	2 months

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. Thomas M.D.
M. D. or other
Address Chesapeake City Md. Date signed Feb 25 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

01627

CERTIFICATE OF DEATH

Reg. Diat. No. 91

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Cecil Memorial Home

How long in hospital or institution? 1 yr 6 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Beulah Rowse

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife: Jos. [illegible]

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1873

8. AGE: Years: about 70 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Collins Beach, Delaware (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: [illegible]

FATHER — 13. Birthplace: [illegible]

MOTHER — 14. Maiden name: [illegible]

MOTHER — 15. Birthplace: [illegible]

16. Informant: [illegible]

Address: Earlville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 27 1945 (month) (day) (year)

Cemetery or crematory: Earlville

Location: Earlville Md.

18. Funeral director: H. W. Pippin & Son per W. A. Grady

Address: Elkton Md.

19. February 27 1945 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 25 1945 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1934 to Feby 1945

and that I last saw her alive on Feby 24 1945

	DURATION
Immediate cause of death: Acute myocarditis	3 days
Due to: Chronic fibro inflammatory disease	25 years
Due to:	
Other conditions: Chronic nephritis (Include pregnancy within 3 months of death)	15 years

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Thos R Davis MD (M. D. or other)

Address: Chesapeake City Md Date signed 2/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01628

Reg. Dist. No. 9Y

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Water St., Powell's Apt.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James O. Rucker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Single.

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 7. 1944

8. AGE:

Years	Months	Days	If less than one day
	6	16	____ hrs. ____ min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business:

FATHER

12. Name: Clarence J. Rucker.

13. Birthplace: Covington, Va

MOTHER

14. Maiden name: Virginia Gill

15. Birthplace: West Va

16. Informant: Mr Ollie Rucker

Address: Powells apt. Elkton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 25 45 (month) (day) (year)

Cemetery or crematory: Elkton

Location: Elkton, Md

18. Funeral director: H. W. Pepperney

Address: Elkton, Md.

19. Feb 24 1945 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 23 1945 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-20 1945, to 2-23-1945 and that I last saw him alive on Feb. 22 1945

Immediate cause of death	DURATION
(a) Bronchio Pneumonia	
Due to Bilateral	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ____ Injured at work?

23. SIGNATURE: R. L. Dodson M.D. M. D. or other

Address: Elkton, Md. Date signed: 2/23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
FEB 28 1945
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87-e)

01629

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs. 10 mo. 24 da.
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County: Cambria
City or town: Conemaugh
(If outside city or town limits, write RURAL and give nearest town)
Street No. 216 Railroad Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I ✓

3. (a) FULL NAME: ST. CLAIR, Virgil

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): May 26, 1894

8. AGE: Years	Months	Days	If less than one day
50	8	20	- hrs. - min.

9. Birthplace: Sarfield, Pa. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: -

FATHER
12. Name: Jacob St. Clair
13. Birthplace: Unknown

MOTHER
14. Maiden name: Emma Litchenfeldt
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 2-15-45 (month) (day) (year)
Cemetery or crematory: Grandview Cemetery
Location: Johnstown, Pa.

18. Funeral director: Pennington & Son
Address: Pennington & Son, Havre de Grace, Md.

19. Feb 15 1945 (Date rec'd by registrar) Irma E. Bengle, A.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 15 1945 at 9:05A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 1931 to February 15 1945 and that I last saw h im alive on February 15 1945

Immediate cause of death	DURATION
Encephalitis, Lethargica, residuals,	
Parkinsonian Syndrome	Over 13 yrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: -
Date of op.: -
Autopsy results: Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of: -
Where did injury occur? - (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -
Means of injury: - Injured at work?

23. SIGNATURE: A. E. Prollinger, Lt. Col., M.C. Clinical Director, Veterans Administration
Address: Perry Point, Md. Date signed: 2-15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77-C)

01630

CERTIFICATE OF DEATH

Reg. Dist. No. 95

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH

County: Cecil

City or town: North East Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: N. Ile County: Cecil

City or town: Lamms

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Lester Sexton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Mulatto	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1899

8. AGE:

Years	Months	Days	If less than one day
45			..... hrs. ..... min.

9. Birthplace: N. C. (town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business

FATHER — 12. Name: Unknown

13. Birthplace: N. C.

MOTHER — 14. Maiden name: Unknown

15. Birthplace: N. C.

16. Informant: Ralph Thomas

Address: North East, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 2 1945 (month) (day) (year)

Cemetery or crematory: West Jefferson N. C.

Location: West Jefferson N. C.

18. Funeral director: J. E. Lynn,

Address: Risingsun Md.

19. Feb 27 1945 (Date rec'd by registrar) L. M. Worthington Registrar

Permit issued 2-27-45

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 24 1945, at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Acute Alcoholism

	DURATION
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. E. Dodson M.D. Medical Examiner Cecil County

M. D. or other

Address: Risingsun Md. Date signed: 2-26-45

US A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01631

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton (If outside city or town limits, write RURAL and give nearest town) Md

How long in above place of death? 65

Hospital, institution, or street address where death occurred: Elkton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)

Street No. Md (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Eva Mae Shaffer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh	Widowed

6.(b) Name of husband or wife: Henry Schaffer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 16, 1879

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
65	10	18		

9. Birthplace: Elkton Md (Town, county, and state)

10. Usual occupation: at Home

11. Industry or business

FATHER — 12. Name: Joseph Covington

FATHER — 13. Birthplace: Elkton, R.D.

MOTHER — 14. Maiden name: No Information.

MOTHER — 15. Birthplace

16. Informant: Lewis Shaffer

Address: Wilmington Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 6 1945 (month) (day) (year)

Cemetery or crematory: Elkton

Location: Elkton, Md

19. Funeral director: H. W. Tilghman

Address: Elkton, Md

19. Feb 6 1945 (Date rec'd by registrar) H R Ferguson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 3 1945 at 12 40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15 1944, to Feb 3 1945 and that I last saw h.. alive on December 30 1945

Immediate cause of death: Acute Coronary Occlusion — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. T. Morrison, M.D. M. D. or other

Address: Elkton Md Date signed 2-5-45

VS A15

PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33-2)

01632

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton - Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Union Hospital
How long in hospital or institution? 7 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 107 Collens St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Rhoda Simpers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widowed

6.(b) Name of husband or wife: Jos Simpers ~~+ John Bowden~~
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 22 1882

8. AGE: Years 62 | Months 8 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace: Elkton - Cecil Co - Md
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: Henry Johnson
13. Birthplace: North East - Md

MOTHER
14. Maiden name: Rachael Wright
15. Birthplace: North East - Md

16. Informant: Elizabeth Simpers - col
Address: Elkton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/20/45 (month) (day) (year)
Cemetery or crematory: Providence Cemetery Elkton
Location: Elkton Md
18. Funeral director: Ezekiel Bell
Address: 909 Poplar St Wilmington Del

19. Feb 19 1945 (Date rec'd by registrar) H Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 17 1945, at 12.55a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 16 - 1945, to Feb 17 1945 - and that I last saw her alive on Feb 16th 1945 -

	DURATION
Immediate cause of death: Uraemic Coma	24 hrs
Due to:	
Due to:	
Other conditions: Influenza -	13 days

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. H. McKnight M.D
M. D. or other
Address: Elkton - Md Date signed 2/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01633

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 5 mo. 4 da.

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as Above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: Tilghman
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: SMITH , Arthur W.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

B.(b) Name of husband or wife: ///// Unknown

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): July 19, 1892

8. AGE: Years	Months	Days	If less than one day
52	6	25	- hrs. - min.

9. Birthplace: Tilghman, Talbot Co., Md.
(Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business: -

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. (Burial, cremation, or removal. Which?): Removal Date thereof: 2-14-45 (month) (day) (year)

Cemetery or crematory: Oak Lawn Cemetery

Location: Baltimore, Md.

18. Funeral director: L. Madison Mitchell
Mitchell Funeral Home

Address: Baltimore, Md. 1900 Eutaw Place

19. 2/14/ 19 45 Irene E. Daughton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13 19 45 at 3:54 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 9 19 41 to February 13 19 45 and that I last saw him alive on February 13 19 45

Immediate cause of death	DURATION
Tuberculosis, pulmonary, bilateral	
Undetermined	
Due to	
Due to	

Other conditions: Psychosis with Paralysis Agitans (Parkinson's Disease) Over 5 years
(Include pregnancy within 3 months of death)

Major findings of operations: -

- Date of op.: -

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: A. E. Roellinger
A. E. ROELLINGER, Lt. Col., M.C., Clinical Director, Veterans Administration
Address: Perry Point, Md. Date signed: 2-14-45

M. D. or other

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-L

CERTIFICATE OF DEATH

01634

Reg. Diat. No. 96

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long is above place of death? 1 yr. 2 mo. 12 days

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 510 -5th Street, N.W., Wash. D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American ✓

3. (a) FULL NAME: SNEE, Thomas A.

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: ////// Unknown

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): April 18, 1859

8. AGE: Years	Months	Days	If less than one day
85	10	1	...m...hrs. ...m...min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: -

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2-19-45 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Feb. 19, 19 45 (Date rec'd by registrar) Registrar: Irene E. Daughaday

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 19, 1945, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 7, 1943, to Feb. 19, 1945 and that I last saw him alive on February 19, 1945

Immediate cause of death	DURATION
Myocardial Insufficiency	Over 14 months
Due to: Myocardial Damage	" 14 months
Due to: Coronary Arteriosclerosis	Over 14 mos.
Other conditions: Psychosis, Senile with Simple Deterioration	Over 14 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.: -

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: A.E. TROLINGER, Lt.Col., M.C. Clinical Director
Or other
Address: Perry Point, Md. Date signed: 2-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

01635

CERTIFICATE OF DEATH

Reg. Diat. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Rowlandsville, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 mos.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? Stanley Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Port Deposit, Md
(If onteide city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)

3. (a) FULL NAME: Charles E. Williams

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
6. (b) Name of husband or wife
6. (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 1863
8. AGE: Years: 81 Months: Days: If less than one day ..... hrs. ..... min.
9. Birthplace: Cecil Co. Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Arthur Williams
13. Birthplace: Md.
MOTHER 14. Maiden name: Mary Badger
15. Birthplace: Md.
16. Informant: Katie Damar
Address: Port Deposit, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 25, 1945 (month) (day) (year)
Cemetery or crematory: Nabeywell
Location: Port Deposit, Md. Rural
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. Feb. 25 1945 Irene E. Dunphy (Registrar)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27 1945 at 7:20 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3, 1945 to Feb. 20 1945
and that I last saw him alive on Feb. 20 1945

	DURATION
Immediate cause of death: Chronic Myocarditis	10 yrs
Due to:	4
Due to:	
Other conditions: Arterio-Sclerosis	6 yrs
Cerebral Hemorrhage	3 hrs

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: C. J. Broom M.D.
M. D. or Coroner
Address: Port Deposit Md. Date signed: 3/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01636

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Perry Point, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17yrs. 5 mo. 23 days
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Erie
City or town: Erie
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1325 German Street
(If rural, give LOCATION)
2.(a) If veteran, name war: W.W. I

3.(a) FULL NAME: WOBLOWSKI, Jan

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): April 12, 1897

8. AGE: Years	Months	Days	If less than one day
47	9	20	- hrs. - min.

9. Birthplace: Randome, Russia
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: Unknown

FATHER
12. Name: John Wablowski
13. Birthplace: Russia

MOTHER
14. Maiden name: Unknown
15. Birthplace: Russia

16. Informant: Hopital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb. 2, 1945 (month) (day) (year)
Cemetery or crematory: Erie Cemetery
Location: Erie, Pa.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Feb. 2 1945 (Date rec'd by registrar) Irene E. Daughtry (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 1 1945 at 5:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 9 1927, to February 1 1945 and that I last saw him alive on February 1 1945.

Immediate cause of death	DURATION
Tuberculosis, pulmonary, chronic	
far advanced, active	3 months
Due to	
Due to	
Other conditions: Dementia Precox, Hebephrenic Type	over 17 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: None performed
Date of op.: -

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of: -
Where did injury occur? (City or town) - (County) - (State)
Injured at home, farm, industry, public place (where?): -
Means of injury: - Injured at work? -

23. SIGNATURE: A. E. Trollinger
TROLLINGER, Lt. Col., M.C., Clinical Director
M.D. or other
Address: Veterans Administration, Perry Point, Md.
Date signed: 2-2-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (78-A)

CERTIFICATE OF DEATH

D1637

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Union Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: S.C. County: Barnwell

City or town: Williston
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II ✓

3.(a) FULL NAME

James Walton WOODWARD

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 8-17-24

8. AGE: Years	Months	Days	If less than one day
20	6	4	..... hrs. ..... min.

9. Birthplace: Williston, S.C.
(Town, county, and state)

10. Usual occupation: U. S. Navy

11. Industry or business

FATHER
12. Name: John Richard Woodward
13. Birthplace: Barnwell County, S.C.

MOTHER
14. Maiden name: Lottie May Hair
15. Birthplace: Blackville, S.C.

16. Informant: John Richard Woodward Jr
Address: Jesup, Georgia

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb 26 1945 (month) (day) (year)
Cemetery or crematory: So. Tolb Funeral Home
Location: Williston South Carolina

18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.

19. Feb 26 19 45 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 February 19 45 at 1:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Bilateral pneumonia	
Due to: Carbon monoxide poisoning	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: Yes. Above findings

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 2-19-45
Where did injury occur? Elkton (City or town) Cecil (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Gas heater Injured at work?

23. SIGNATURE: R. L. Woodward M.D. Medical Examiner Cecil County
Address: Rising Sun Md. M. D. or other Date signed: 2-20-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

CERTIFICATE OF DEATH

01638

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: CECIL
City or town: PERRY POINT, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs, 10 mo. 11 da.
Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 425 E. Hamburg St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: W.W. I

3.(a) FULL NAME: YOUNG, Walter Douglas

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Gertrude (E) Maiden name unknown
6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): June 27, 1870

8. AGE: Years	Months	Days	If less than one day
74	7	29	- hrs. - min.

9. Birthplace: Auburn, New York (Town, county, and state)
10. Usual occupation: Electrical Engineer
11. Industry or business: -

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administrati on, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 2-26-45 (month) (day) (year)
Cemetery or crematory: LOUDON PARK CEMETERY
Location: Baltimore, Md.

18. Funeral director: Harry W. Witzke, per C.E.W. Harry Witzke
Address: 1401 Edmondson Ave., Balto., Md.

19. Feb. 26, 1945 (Date rec'd by registrar) Irene E. Dunkle, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 25, 1945, at 1:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14, 1937, to Feb. 25, 1945, and that I last saw him alive on February 25, 1945.

	DURATION
Immediate cause of death: Myocardial Insufficiency	Over 4 yrs.
Due to: Myocarditis, chronic	Over 4 yrs.
Due to:	
Other conditions: Involutional Melancholia	Over 7 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: -
Date of op.: -
Autopsy results: Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of: -
Where did injury occur? - (City or town) - (County) - (State)
Injured at home, farm, industry, public place (where?): -
Means of injury: - Injured at work? -

23. SIGNATURE: C.E. TROLLINGER, Lt.Col. M.C. Clinical Director, Veterans Administration, M.D. or other
Address: Perry Point, Md. Date signed: 2-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING